STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 01 B. WING	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON HEALTH CARE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/28/12 Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Washington Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in all resident rooms. The facility has a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 94 and had a census of 84 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/03/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 46 resident room corridor doors latched into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of Room 205. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, the latching mechanism for the corridor door to resident Room 205 failed to latch the door into the door frame when the door was closed. Based on interview at the time of observation, the Maintenance Supervisor stated the latching mechanism in the door wasn't functioning and acknowledged the	K0018	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The latching mechanism for the corridor door was repaired on 4/9/12, with door repair enabling door to latch into the door frame when the door is closed. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The latching mechanism for the corridor door was repaired on 4/9/12, with the door repair enabling door to latch into the door frame when the door is closed. All doors protecting corridor openings, such as resident room doors or applicable	04/23/2012

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	corridor door to resident Room 205 failed to latch into the door frame when the door was closed. 3.1-19(b)		doors, will be reviewed by 4/18/12 to ensure the door latches into the door frame when the door is closed. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All doors protecting corridor openings, such as resident room doors or applicable doors, will be reviewed by 4/18/12 to ensure the door latches into the door frame when the door is closed. An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of the requirement for resident room doors to latch into the door frame when the door is closed. A Life Safety Review audit tool will be utilized weekly x 4 weeks, monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety Review audit tool will be utilized by Maintenance Supervisor weekly x 4 weeks, monthly x 2, and quarterly thereafter to ensure doors latch into the door frame when the door is closed. The Quality Assurance committee will review the data. If 90% threshold is not achieved, an action plan will be developed.	

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 openings through the ceiling into the attic above the boiler room was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of the boiler room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, there is a three foot by fifteen inch hole in the ceiling in the boiler room which is not firestopped. Based on interview at the time of observation, the Maintenance Director stated a water leak this past winter damaged the ceiling causing the hole in the ceiling and acknowledged there is a	K0025	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The three foot by fifteen inch hold in the ceiling in the boiler room was repaired and firestopped on 4/9/12 by maintenance staff. A building review was completed on 4/912 with no further concerns in smoke barriers identified. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. The three foot by fifteen inch hold in the ceiling in the boiler room was repaired and firestopped on 4/9/12 by maintenance staff. A building review was completed on 4/912 with no further areas identified. What measures will be put into	04/23/2012

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	three foot by fifteen inch hole in the ceiling in the boiler room which is not firestopped. 3.1-19(b)		place or what systematic changes will you make to ensure that the deficient practice does not recur? When repairs or building damage occurs in the future, facility will review areas to ensure these area are maintained to provide at least one half hour fire resistance rating. Another building review will by conducted by 4/23/12 to ensure smoke barriers are being maintained to provide at least a one half hour fire resistance rating. An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of smoke barriers. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure smoke barriers are constructed and maintained to provide at least a one half hour fire resistance rating. The CQI committee will review the data. If 90% threshold is not achieved, an action plan will be developed.	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 8 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the Central Supply storage room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, the access door to the Central Supply storage room is not equipped with a self closing device to latch the door into the door frame. The Central Supply storage room measures	K0029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A new self-closing device was installed on the Central Supply storage room on 4/9/12. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. A review of storage rooms and other doors was performed on 4/9/12 to ensure these doors serving areas that may be hazardous or store combustible items has a self-closing device. Another review will be completed by 4/23/12 to ensure doors serving areas that may be hazardous or store combustible items have self-closing device. What measures will be put into place or what systematic changes	04/23/2012

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	165 square feet and is used to store combustible boxes and diapers. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Central Supply storage room measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a self closing device. 3.1-19(b)		will you make to ensure that the deficient practice does not recur? Another review will be completed by 4/23/12 to ensure doors serving areas that may be hazardous or store combustible items have self-closing device. An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of need self-closing devices on applicable doors. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter. When renovation or repairs occur in the future, facility will review areas to ensure these areas are maintained to provide self-closing device on doors serving applicable areas that may contain hazards or store combustible items. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure doors serving areas that may be hazardous or store combustible items have self-closing device. The CQI committee will review the data. If 90% threshold is not achieved, an action plan will be developed.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 delayed egress locks was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that: (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect any resident, staff or visitor wanting to exit the facility by using the front lobby exit. Findings include:	K0038	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 4/2/12 a readily visible and durable sign was placed adjacent to the reading PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. A more permanent readily visible and durable sign will be placed adjacent to release device on door by 4/23/12. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. On 4/2/12 a readily visible and durable sign was placed adjacent to the reading PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. A more permanent readily visible and durable sign will be placed adjacent to release device on door by 4/23/12. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of delayed	04/23/2012

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	Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, the front lobby exit door is equipped with a delayed egress lock which can be opened by the application of force to the release device within 15 seconds but the exit door was not provided with signage stating the door could be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the front lobby exit door is equipped with a delayed egress lock but the exit door does not have signage stating the door can be opened within 15 seconds of the application of force to open the door. 3.1-19(b)		egress on applicable doors. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure delayed egress doors marked with PUSH UNTIL ALARM SOUND. DOOR CAN BE OPENED IN 15 SECONDS. The CQI committee will review the data. If 90% threshold is not achieved, an action plan will be developed.	

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K0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, documentation was not available for review for a fire drill conducted on the second shift for the second and third quarters of 2011. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation available for review of a fire drill being conducted on the second shift for the second and third quarters of	K0050	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Fire drills will be conducted at least quarterly on each shift, at unexpected times under varying conditions. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Fire drills will be conducted at least quarterly on each shift, at unexpected times under varying conditions. A fire drill for second shift will be conducted by 4/23/12 for second quarter of 2012. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Fire drills will be conducted at least quarterly on each shift, at unexpected times under varying	04/23/2012

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	2011. 3.1-19(b)		conditions. Fire drill reports will be kept in Maintenance Supervisor office with copy of fire drill reports in Executive Director's office. A Life Safety audit tool for fire drills will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure the requirement is met for fire drills to be conducted at least quarterly on each shit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool for fire drills will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure the requirement is met for fire drills to be conducted at least quarterly on each shift. The CQI committee will review the data. If 95% threshold is not achieved, an action plan will be developed.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 portable K class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents, staff or visitors in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Supervisor during a tour of	K0064	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A permanent placard for K class portable fire extinguisher in the kitchen was placed adjacent to K class portable fire extinguisher, stating the fire protection system shall be activated prior to using the K class portable fire extinguisher. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. A permanent placard for K class portable fire extinguisher in the kitchen was placed adjacent to K class portable fire extinguisher, stating the fire protection system shall be activated prior to using the K class portable fire extinguisher. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? An inservice for all staff will be completed by 4/23/12 to educate staff on awareness of the requirement for K class extinguisher that fire protection	04/23/2012

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	the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, a placard was not conspicuously placed near the K class portable fire extinguisher which states the fire protection system shall be activated prior to using the K class portable fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the K class portable fire extinguisher stating the fire protection system shall be activated prior to using the K class portable fire extinguisher. 3.1-19(b)		system shall be activated prior to using the K class portable fire extinguisher. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure the placement of placard for K class portable fire extinguisher(s). How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure the placement of placard for K class portable fire extinguisher(s). The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was enclosed with a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, the oxygen storage and transfilling room contained four liquid oxygen canisters and had a ceiling with one layer of five eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the ceiling did not provide one hour fire resistive construction for the oxygen storage and	K0076	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Ceiling of the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to meet requirement of fire barrier of 1 hour fire resistive construction. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Ceiling of the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to meet requirement of fire barrier of 1 hour fire resistive construction. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? When renovation or repairs occur in the future, the facility will review	04/23/2012

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	transfilling room. 3.1-19(b)		areas to ensure that there is separation of a fire barrier of 1-hour fire-resistive construction between rooms utilized for storage and transferring of oxygen. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement of fire barrier of 1 hour fire resistive construction is maintained. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement of fire barrier of 1 hour fire resistive construction is maintained. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/28/12, the oxygen storage and transfilling room contained four liquid	K0143	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Ceiling of the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to meet requirement of fire barrier of 1 hour fire resistive construction. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Ceiling of the oxygen storage and transfilling room had additional ceiling installed on 4/9/12 to meet requirement of fire barrier of 1 hour fire resistive construction. What measures will be put into	04/23/2012

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	oxygen canisters and had a ceiling with one layer of five eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the ceiling did not provide one hour fire resistive construction for the oxygen storage and transfilling room. 3.1-19(b)		place or what systematic changes will you make to ensure that the deficient practice does not recur? When renovation or repairs occur in the future, the facility will review areas to ensure that there is separation of a fire barrier of 1-hour fire-resistive construction between rooms utilized for storage and transferring of oxygen. A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement of fire barrier of 1 hour fire resistive construction is maintained. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement of fire barrier of 1 hour fire resistive construction is maintained. The CQI committee will review the data. If 100% threshold is not achieved, an action plan will be developed.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 30 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency	K0144	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Generator will be inspected weekly and exercised under load for 30 minutes per month, and recorded. Emergency Generator/Load Testing log will include percentage load capacity, minimum exhaust gas temperatures, and time it takes to transfer power from the main source to the emergency generator. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Generator will be inspected weekly and exercised under load for 30 minutes per month, and recorded. Recordings will percentage load capacity, minimum exhaust gas temperatures, and time it takes to transfer power from the main source to the emergency generator. What measures will be put into place or what systematic changes will you make to ensure that the deficient	04/23/2012

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	Generator Checks" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, weekly emergency generator starting battery inspection records for the twenty eight week period of 04/02/11 through 05/28/11 and 11/05/11 through 03/24/12 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged weekly emergency generator starting battery inspection records for the twenty eight week period of 04/02/11 through 05/28/11 and 11/05/11 through 03/24/12 were not available. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 7 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires		practice does not recur? Maintenance Supervisor or designee will conduct the weekly generator inspections, exercising under load for 30 minutes per month and record on Emergency Generator/Load Testing log. A CQI tool for Life Safety Review will be utilized weekly x 4 and monthly thereafter to ensure the requirement is met. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Maintenance Supervisor or designee will conduct the weekly generator inspections, exercising under load for 30 minutes per month and record on Emergency Generator/Load Testing log. A CQI tool for Life Safety Review will be utilized weekly x 4 and monthly thereafter to ensure the requirement is met for generator inspections weekly and exercised under load for 30 minutes per month, and recorded. The CQI committee will review the data. If 90% threshold is not achieved, an action plan will be developed.	

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	generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Checks" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, monthly load test documentation was not available for review for the period of March 2011 through May 2011 and November 2011 through February 2012. Based on interview at the time of observation, the Maintenance Director acknowledged			

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	there was no documentation available for review for the period of March 2011 through May 2011 and November 2011 through February 2012. 3.1-19(b) 3. Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Exercising/Load Testing" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, the emergency generator was run on a monthly basis for at least thirty minutes each month for the period of 06/11/11 through 10/15/11 but the logs utilized by the facility recorded the time to transfer			

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	power from the main source to the emergency generator as the time of day the load test was conducted. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the transfer time to transfer power to the emergency generator for the period of 06/11/11 through 10/15/11 was recorded as the time of day the load test was conducted and not how long it took to transfer power from the main source to the emergency generator. 3.1-19(b)			

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K0154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 84 of 84 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Watch Policy and Procedure" documentation with the	K0154	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility's fire watch policy was updated on 4/12/12. The updated Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be placed out of service or is out of service for 4 hours or more in a 24 hour period. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Facility's fire watch policy was updated on 4/12/12. The updated Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be	04/23/2012

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	Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, "Procedure" states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of observation, the Maintenance Supervisor stated the facility's written fire watch policy requires notification of the necessary entities only in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b)		placed out of service or is out of service for 4 hours or more in a 24 hour period. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All Disaster and Emergency Preparedness manuals in facility updated with new Fire Watch policy by 4/23/12. All staff will be inserviced by 4/23/12 on updated Fire Watch policy including the requirement of notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be placed out of service or is out of service for 4 or more hours in a 24 hour period. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement is met for appropriate notifications of the Indiana State Department of Health, alarm company, local fire department, and building owner for any event is which automatic sprinkler system or fire alarm system are out of service for more than 4 hours in 24 hour period. The CQI committee will review the data. If 100%	

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			threshold is not achieved, an action plan will be developed.	

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K0155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 84 of 84 residents. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Watch Policy and Procedure" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 03/28/12, "Procedure" states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authorities having jurisdiction, the Indiana State Department of Health and the local fire department, would only be notified in the event of a fire. Based on interview at the time of	K0155	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility's fire watch policy was updated on 4/12/12. The updated Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be placed out of service or is out of service for 4 hours or more in a 24 hour period. How will you identify other Residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents currently living in the facility, visitors, and staff have the potential to be affected by the alleged deficient practice. Facility's fire watch policy was updated on 4/12/12. The updated Fire Watch policy includes notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be	04/23/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation, the Maintenance Supervisor stated the facility's written fire watch policy requires notification of the necessary entities only in the event of a fire and acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health and the local fire department would occur in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b)		placed out of service or is out of service for 4 hours or more in a 24 hour period. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? All Disaster and Emergency Preparedness manuals in facility updated with new Fire Watch policy by 4/23/12. All staff will be inserviced by 4/23/12 on updated Fire Watch policy including the requirement of notification of the Indiana State Department of Health, alarm company, local fire department, and building owner in the event the automatic sprinkler system or fire alarm system has to be placed out of service or is out of service for 4 or more hours in a 24 hour period. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A Life Safety audit tool will be utilized by Maintenance Supervisor or designee weekly x 4 , monthly x 2, and quarterly thereafter to ensure requirement is met for appropriate notifications of the Indiana State Department of Health, alarm company, local fire department, and building owner for any event is which automatic sprinkler system or fire alarm system are out of service for more than 4 hours in 24 hour period. The CQI committee will review the data. If 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155383	A. BUILDING 01 B. WING	03/28/2012

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			threshold is not achieved, an action plan will be developed.	